Texas Department of Insurance
Division of Workers' Comp
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

METHODIST CHARLTON MEDICAL CENTER
4040 N CENTRAL EXPY SUITE 601
DALLAS TX 75204

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box
Box Number 54

MFDR Tracking Number
M4-07-4631-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "@ cost plus 10%."

Amount in Dispute: $7,021.52

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Rule 134.401(c)(4)(C) states that pharmaceuticals with a charge greater than $250/dose shall be reimbursed at cost plus 10%. The medication, Crofab, falls into this category." "Texas Mutual reviewed the medications invoice submitted by the Requestor. (Exhibit 2) This invoice documents that each carton of Crofab contains two vials. Each carton cost $2,129.54. Texas Mutual issued payment for five cartons at $2,129.54/carton plus 10%." "Texas Mutual also issued payment for a one day ICU admission at the per diem of $1,560.00."

Response Submitted by: Richard Ball, Texas Mutual Insurance Co., 6210 East Hwy 290, Austin, TX 78723

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
September 21, 2006	Inpatient Services – Revenue Code 252	$7,021.52	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401, effective August 1, 1997, 22 TexReg 6264, sets out the reimbursement guidelines for inpatient hospital services.
3. This request for medical fee dispute resolution was received by the Division on March 16, 2007.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - CAC- W1-Workers Compensation state fee schedule adjustment.
   - 480-Reimbursement based on the Acute Care Inpatient Hospital Fee Guideline per diem rate allowances.
   - CAC-18-Duplicate claim/service.
   - 878-Duplicate appeal. Request medical dispute resolution through DWC for continued disagreement of original appeal decision.

Findings

1. This dispute relates to inpatient pharmaceuticals provided during a hospital stay with reimbursement subject to the provisions of 28 Texas Administrative Code §134.401.
2. 28 Texas Administrative Code §134.401(c)(4), states "Additional reimbursement. All items listed in this paragraph shall be reimbursed in additional to the normal per diem based reimbursement system in accordance with the guidelines established by this section. Additional reimbursement apply only to bills that do not reach the stop-loss threshold described in subsection (c)(6) of this section."
3. 28 Texas Administrative Code §134.401(c)(4)(C), states "Pharmaceuticals administered during the admission and greater than $250 charged per dose shall be reimbursed at cost to the hospital plus 10%. Dose is the amount of a drug or other substance to be administered at one time."

   The claimant was bitten by a copperhead snake and administered nine vials of antivenin (Crofab) injections.

   Based upon the submitted invoice, each carton of Crofab contained two vials. The cost to the hospital was $2,129.54 per carton. Therefore, nine vials of Crofab equals four and a half cartons. The respondent stated that they paid for five cartons.

   The formula to determine the appropriate reimbursement per 28 Texas Administrative Code §134.401(c)(4)(C), is: $2,129.54 per carton plus 10% = $2,342.49 multiplied by five cartons = $11,712.45. The respondent paid $11,718.45. No additional reimbursement can be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 3, 2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.